STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METROCENTER
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF DENTISTRY
(615) 532-3202 or 1-800-778-4123
www.Tennessee.gov/health

APPLICATION INSTRUCTIONS FOR LICENSURE AS A DENTAL HYGIENIST

I. THE APPLICATION PROCESS

Application, practice, and renewal as dental hygienist is governed by T.C.A.§63-5-101, et. seq. And Rules 0460-1-.01, et. seq**.**

1. All **application fees are non-refundable**.
2. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:

> **Tennessee Board of Dentistry**
> **First Floor, Cordell Hull Building**
> **425 Fifth Avenue North**
> **Nashville, TN 37247-1010**

3. Allow fourteen (14) working days for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not reduce the processing time. Additionally, if Federal Express or special courier services are used you will be responsible for charges incurred.
4. **We will discuss application status with the applicant or applicant's spouse only**. Please inform hospitals, employers, recruiters, referral companies, or insurance companies that application status updates must be obtained from you.
5. If the application is not complete upon receipt by the Board's administrative office, a deficiency letter will be sent to you by certified mail. The supporting documentation requested in the letter must be received in the Board's administrative office sixty (60) days from the date of the initial deficiency letter. **Files not completed within sixty (60) days will be closed.**
6. It is recommended that you do **not** make arrangements to practice as a Dental Hygienist in Tennessee until you are granted a license by the Tennessee Board of Dentistry.
7. **IT'S THE LAW!** If you change your mailing address, you must notify the Board's Administrative Office, in **writing,** within thirty (30) days. Failure to abide by this law could affect your license, since failure to receive the renewal application does not relieve you of the responsibility for timely renewal.
8. ANSWER ALL QUESTIONS ON THE APPLICATION. DO NOT LEAVE ANY AREA BLANK. RESPOND "NOT APPLICABLE" or (N/A) TO ALL QUESTIONS THAT DO NOT APPLY!

> **IMPORTANT: You must have a license issued by the Tennessee Board of Dentistry in your possession before you may lawfully practice as a Dental Hygienist in Tennessee.**

There are three (3) avenues for licensure as a dental hygienist in Tennessee. Below are definitions of each avenue. Please carefully read and determine the process that is applicable to you.

1. **Examination** - This requirement is applicable to any dental hygienist who has successfully completed one of the following examinations: Southern Regional Testing Agency (SRTA) or Western Regional Examining Board (WREB, and has not actively practiced full-time for three (3) of the preceding five (5) years in another state. Please refer to Rule 0460-3-.01 for more information.

2. **Criteria Approval** - This requirement allows a dental hygienist who is licensed in another State and has actively practiced full-time for three (3) of the preceding five (5) years to be considered for licensure without taking a regional examination. The SRTA examination must never have been failed to qualify by criteria approval. Please refer to Rule 0460-3-.02 for more information.

3. **Limited Educational License** - This process is applicable to a dental hygienist licensed in another state and who will be teaching in a dental hygiene educational institute. This type of license limits the practice location to programs offered by the educational institution. Upon termination of faculty appointment the license is void. This type of licensure requires a special type of application. Please request this application from our office. Please refer to Rule 0460-3-.03 for more information.

II. CHECKLIST – USE TO COMPLETE YOUR APPLICATION.

NOTE: All submissions must be executed and dated less than one (1) year before receipt, or they will be rejected by the Board.

		Done
1.	Tape to the first page of the Application a passport-size photograph of yourself (taken within the last twelve (12) months); then sign your name on the front of the photograph.	_____
2.	Complete pages 1 through 6 of the Application. Sign page 6 of the Application in the presence of a Notary; then, mail all six (6) pages to the Board's Office.	_____
3.	Complete and mail **Attachment 1** to the institution from which you completed your Dental Hygiene program to request that an official transcript be mailed directly to the Board of Dentistry.	_____
4.	If you **are** or **have ever been** licensed, certified, registered, or permitted by any state to practice as a Dental Hygienist (or any other health care professional), you must complete and mail **Attachment 2** to each and every state. Copies of **Attachment 2** may be duplicated to accommodate each request.	_____
5.	Please complete and mail **Attachment 3** to the American Dental Association to have your National Board scores forwarded directly to the Board of Dentistry.	_____
6.	Submit two (2) original letters of recommendation on the signator's letterhead from dental professionals who can attest to your character as a Dental Hygienist. These letters must identify the individuals as dental professionals and **must be originals**. ***If applying by criteria, the letters of recommendation must be from Dentist.***	_____
7.	**If applying by criteria**, proof of full-time practice as a dental hygienist in another state for three (3) of the preceding five (5) years must be submitted from previous employers.	_____
7.	Copy the front and back of your current CPR card and tape the copies to a full- sized sheet of paper. Submit these copies with your 6-page Application to the Board.	_____
8.	Attach proof of U.S. or Canadian citizenship or evidence of being legally entitled to live in the U.S. (e.g. copy of birth certificate, voter's registration card, naturalization papers, or current visa status.)	_____
9.	**Paperclip a check or money order in the amount of One Hundred Twenty-Five Dollars ($125), if applying by examination, or One Hundred Seventy-Five Dollars ($175), if applying by criteria, made payable to the Board of Dentistry to the front of the Application.**	_____

10. **If any of your answers to the "competency questions" on pages 4 and 5 of the Application were in the affirmative, please submit a separate document to explain the situation.** Please read the instructions on page 4 of the Application carefully. You must answer "Yes","No",or "N/A" to **every** question. _____

11. If you took the Southern Regional Testing Agency (SRTA) examination within the last five (5) years, your scores were automatically sent to the Board of Dentistry and do not need to be requested from SRTA. If you took the Western Regional Examining Board (WREB) examination, you will need to request that the testing agency send your scores directly to the Board's Administrative office. _____

NOTE: Anyone who took the SRTA or WREB examination **more than five (5) years ago** will need to request your scores be sent directly to the Board's Administrative office, **and** you will be required to appear before the Board for an interview at the next regularly scheduled meeting of the Board (normally January, May and September) if you do not qualify for licensure by the criteria method. To have your scores mailed, please contact SRTA at (757)428-1003 or www.srta.org or WREB at (602)944-3315 or www.wreb.org. **Tennessee does not accept any state clinical, North East Regional Board of Dental Examiners (NERB) or the Central Regional Dental Testing Service (CRDTS) examination at this time.**

12. A criminal background check is required. For instructions to obtain a criminal background check, ***click here*** or go to the Noteworthy section of the Board's website. _____

13. Applicants who have failed the National Board or any regional examination three (3) times must successfully complete a remedial course of post-graduate studies as a school accredited by the ADA before consideration for licensure by the Board. The program director of the post-graduate program must provide written documentation of the content of such course and certify successful completion. _____

IT'S THE LAW! If you change your mailing address, you must notify the Board's Administrative Office, in **writing,** within thirty (30) days. Failure to abide by this law could effect your license, since failure to receive the renewal application does not relieve you of the responsibility for timely renewal.

ATTACH A CURRENT FULL-FACE PHOTOGRAPH (SIGNED BY APPLICANT ON THE FRONT OF THE PHOTOGRAPH)

FOR OFFICIAL USE ONLY

BY EXAM

1202-001	$115
1202-006	$ 10
	$125

BY CRITERIA

1202-001	$115
1202-001	$ 50
1202-006	$ 10
	$175

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DENTAL HYGIENE
APPLICATION FOR LICENSURE

Please complete each question and return the form, supporting documents, and the appropriate application fee to the above address.

PERSONAL INFORMATION

PLEASE PRINT IN INK

Name: _____
Last First Middle Maiden (if not used as your middle name)

Social Security Number: ___ - ___ - ___ Date of Birth: _____

Mailing Address: _____ County (TN Applicants Only): _____
(Residence) _____
_____ Phone: Home: ( )
Zip Office: ( )

Practice Address: _____
_____
_____
Zip

Place of Birth: _____ Sex: (optional-for statistical purposes only)
Female ____
U.S. Citizen: Yes ___ No ___ Male ____

Have you ever been known by any other names besides what is listed above? Yes ___ No ___

If yes, please state in full every other name by which you have been known, the reason therefore, and inclusive dates so known. _____
_____

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all educational institutions you have attended beyond high school. Use the back of this page if you need additional space. (SEND ATTACHMENT #1 TO THE EDUCATIONAL INSTITUTION WHERE YOU COMPLETED YOUR DENTAL HYGIENE PROGRAM.)

From: Mo./Yr.	To: Mo./Yr.	Educational Institution	City, State	Degree Earned	Year Graduated

Please complete your entire employment history starting with the most current position first. Use the back of this page if you need additional space. (If you have never worked in the Dental Hygiene profession, list the other positions in which employed.)

Company/ Employer:	Address: (Street, City, and State)	Position:	Duties:	Dates From: Mo./Yr.	Dates To: Mo./Yr.

CERTIFICATION INFORMATION

List below **ALL STATES, COUNTRIES, OR PROVINCES IN WHICH YOU HAVE EVER BEEN OR ARE CURRENTLY LICENSED, PERMITTED, OR CERTIFIED** as a Dental Hygienist. Additional pages may be added if necessary. Submit a copy of **Attachment #2** to all such states, countries, or provinces regarding such licensure, certification, or permit. Use the back of this page if you need additional space. **If this section does not apply, mark N/A.**

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

List below **ALL** states, countries, or provinces in which you hold or have ever held a license, certification, or permit as a health professional other than a Dental Hygienist. Submit a copy of **Attachment #2** to all such states, countries, or provinces regarding such licensure, certification, or permit. Use the back of this page if you need additional space. **If this section does not apply, mark N/A.**

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

		YES	NO
1.	Are you certified by the National Boards?		
2.	Have you ever previously applied for a dentist, dental hygiene, or dental assisting license in Tennessee?		
3.	Are you certified by the Southern Regional Testing Agency (S.R.T.A.)?		
4.	Are you certified by the North East Regional Board of Dental Examiners (NERB)?		
5.	Are you certified by the Western Regional Examining Board (WREB)?		
6.	Are you certified by the Central Regional Dental Testing Service (CRDTS)?		

The regional scores are only effective for five (5) years from the date you take the examination. Please indicate below which regional exam you took, the exam site and the date when you successfully completed the examination. (If scores are more than five (5) years old, refer to Paragraph 12, page 3 of the Checklist.)

Regional Exam Taken: _____

Exam Site: _____

Date Exam Taken: _____

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the **affirmative**, attach an explanation on a separate sheet. ***In support of your explanation, the final documents or orders from the issuing states, courts, and/or agencies must be submitted along with this application***. **Please respond to ALL questions.**

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:
   a. The cognitive capacity to make appropriate clinical diagnosis (if necessary), exercise reasoned judgments, to learn, and keep abreast of developments in your profession;
   b. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
   c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **"Medical Condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disability, HIV disease, tuberculosis, drug addiction; and alcoholism.
3. **"Chemical substances"** is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
4. **"Currently"** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.
5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS:	**YES**	**NO**
1. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?	___	___
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program?	___	___
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	___	___

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.]

COMPETENCY INFORMATION CONTINUED

QUESTIONS		YES	NO
2.	Do you currently use chemical substances?	____	____
	If yes, do they in any way impair or limit your ability to practice medicine with reasonable skill and safety?	____	____
3.	Are you currently engaged in the illegal use of controlled substances?	____	____
	If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	____	____
4.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?	____	____
5.	If you have held or applied for a license or certificate to practice as a Dental Hygienist in any state, country, or province, has or was it ever been denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, voluntarily surrendered under threat of investigation, or disciplinary action?	____	____
6.	If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited, otherwise disciplined, voluntarily surrendered under threat of restriction, or disciplinary action?	____	____
7.	Have you ever failed a dental hygiene examination? (National Boards, regional or state) If yes, how may times have you failed? _____	____	____
8.	Have you ever applied for and been denied a state or federal controlled substance certificate?	____	____
	If you have possessed such a certificate has it ever been revoked, suspended, restricted, or otherwise disciplined, voluntarily surrendered under threat of investigation, or disciplinary action?	____	____
9.	Have you ever been convicted of a felony or a misdemeanor other than a minor traffic offense?	____	____
10.	Have you ever been rejected or censured by a dental society?	____	____
11.	In relation to the performance of your professional services in any profession:		
	a. Have you ever had final judgment rendered against you;	____	____
	b. Have you ever had settlement of any legal action rendered against you; or	____	____
	c. Are there any legal actions pending against you or to which you are a party?	____	____
12.	If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, voluntarily surrendered under threat of investigation, or disciplinary action?	____	____

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC

AFFIDAVIT AND RELEASE

I, _____, of _____,
(Applicant's Name) *(City)* *(State)*
being duly sworn and identified as the person referred to in this application and signed photo, attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations which were enclosed in the application packet and agree to abide by them in the practice as a dental hygienist in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as a Dental Hygienist.

AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without the malice concerning my competence, ethics, character, other qualifications, for licensure.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and for resolving any doubts about such qualifications.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
SIGNATURE **DATE**

Sworn to before me this _____ day of _____, 20 _____.

_____ Affix Seal Here
NOTARY PUBLIC

My Commission Expires _____

ATTACHMENT #1

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METROCENTER
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF DENTISTRY
1-888-310-4650 Ext. 25073

EDUCATION VERIFICATION

APPLICANT: Supply the information requested in this box and then mail this entire form to the school at which you completed your Dental Hygiene program. NOTE: Most schools require a fee, so you may want to contact the institution before mailing this form so that you can attach their fee.

TO WHOM IT MAY CONCERN:

I am applying for a license to practice as a Dental Hygienist in the State of Tennessee. The Board of Dentistry requires verification of educational attainment. Please forward an original transcript bearing the institution's official seal to the Boards address below.

Applicant's Full Name: _____
(Last) (First) (Middle/Maiden)

Applicant's Address: _____
_____
_____
_____

Applicant's Social Security Number: _____ - _____ - _____

Applicant's Student Identification Number: _____

Year of Graduation: _____

Degree Conferred: _____ Date Degree Conferred: _____

Please forward an original graduate transcript bearing the institution's official seal to:

Tennessee Board of Dentistry
227 French Landing, Suite 300
Heritage Place MetroCenter
Nashville, TN 37243

Thank you for your cooperation and prompt response.

_____ _____
Applicant's Signature Date

ATTACHMENT #2

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METROCENTER
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF DENTISTRY

CLEARANCE FROM OTHER STATE LICENSURE BOARDS

APPLICANT: Please provide the information requested in the top box and then mail one (1) form to the licensure board in EACH state where you hold or have ever held a license to practice any profession. (Copies of this form can be used). NOTE: Some states require a fee for providing clearance information. To expedite your application, you may wish to contact the applicable state(s).

To Be Completed By Applicant (Please Print In Ink)

I, the undersigned applicant, was granted a **(circle one)** license or certificate to practice _____
(Profession)
numbered _____ on _____ in the State of _____.
(Date)
The Tennessee Board of Dentistry requests that I submit evidence of the current status of that license in your state.

You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Board of Dentistry.

Date	Applicant's Signature	Applicant's typed or printed name
_____	_____	_____

ADMINISTRATIVE OFFICE OF STATE LICENSURE BOARD, PLEASE COMPLETE:

Name in full as it appears on license/certificate or permit:

_____
(First) (M.I.) (Last)

License/Certificate/Permit Number: _____ Profession: _____

Date Issued: _____ Expiration Date: _____

Basis of Issuance: _____ Endorsement/Reciprocity with _____
(check one) (State)
_____ Written Examination _____

Is there any derogatory information on file? Yes _____ No _____ If yes, please attach supporting documentation.

Authorized Signature	Title	Date
_____	_____	_____

State Seal

Please mail directly to: **Tennessee Board of Dentistry**
227 French Landing, Suite 300
Heritage Place MetroCenter
Nashville, TN 37243

_____
State

ATTACHMENT #3

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METROCENTER
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF DENTISTRY

NATIONAL BOARD VERIFICATION

Please complete the top portion of this form, attach a **MONEY ORDER** OR **CERTIFIED CHECK in the amount of Fifteen Dollars $15.00** MADE PAYABLE TO THE AMERICAN DENTAL ASSOCIATION, and mail it to the address below.

Send to:

DEPARTMENT OF TESTING SERVICES
AMERICAN DENTAL ASSOCIATION
211 EAST CHICAGO AVENUE, SUITE 1846
CHICAGO, IL 60611

TO BE COMPLETED BY APPLICANT (PLEASE PRINT IN INK)

Dear National Board Official:

I am applying for a license to practice as a Dental Hygienist in the State of Tennessee. The Tennessee Board of Dentistry requires that a copy of my scores be **forwarded directly to their** office by the National Boards.

Applicant's Name _____
(First) (M.I.) (Last)

Social Security No.: ____-____-____ Date National Certified _____

Name of Institution from which you graduated: _____

Date you graduated from the Dental Hygiene Program: _____

Year of Birth: _____

PLEASE MAIL SCORE VERIFICATION DIRECTLY TO:

TENNESSEE BOARD OF DENTISTRY
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METROCENTER
NASHVILLE, TN 37243